FY 2008 and FY 2009 CSHCS Application for Funding
Maternal & Children's Special Health Care Programs

ISDH Maternal and Children's Special Health Care Services Division (MCSHC) makes funds available for specific programs using this Grant Application Procedure (GAP). This GAP has been specifically designed for the Spina Bifida program.

Instructions

1. An application for Maternal & Children's Special Health Care Services (MCSHC) funds must be received by ISDH MCSHC.

2. Mail application to: Indiana State Department of Health
   ATTENTION: Kimberly Rief
   2 North Meridian Street, Section 8C
   Indianapolis, IN 46204

3. Submit the original proposal and three copies. Do not bind or staple.

4. The application must be typed (no smaller than 12 pitch, printed on one side only) and double-spaced. Each page must be numbered sequentially beginning with Form A, the Applicant Information page.

5. The narrative sections of the application must not exceed 30 double spaced typed pages. Applications exceeding this limit will not be reviewed.

6. Appendices, excluding C.V.'s, must not exceed 20 pages. Appendices that serve only to extend the narrative portion of the application will not be accepted.

7. The application must follow the format and order presented in this guidance. Applications that do not follow this format and order will not be reviewed.

8. The application will not be reviewed if all sections are not submitted.

Note: Questions about this application should be directed to Robert Bruce Scott, Grants Coordinator, at rbscott@isdh.in.gov or 317/233-1241, or Bob Bowman, Director, Newborn Screening at bobbowman@isdh.in.gov or 317/233-1231.

Informing Local Health Officers of Proposal Submission

Funded projects are expected to collaborate with local health departments. If you are unable to submit a letter of support from the local health officer, at a minimum, submit copies of letters sent to the local health officers, from all jurisdictions in the proposed service area, informing them of your application. These letters should include requests for support and collaboration and indicate that the proposal was included for review by the health officer(s).

FORMS

Applicant Information (Form A)

CSHCS Project Description (Forms B-1 and B-2) *NOTE: B1 does not substitute for a project summary.*

Funding Currently Received by Your Agency from ISDH (Form C)

APPENDICES

Appendix A – Genetic Services Annual Performance Report

Appendix B –Definitions (CSHCS and Genetic Services)

Appendix C – Grant Application Scoring Tool

WEBSITES

- Application with linkages to data: http://www.state.in.us/isdh/programs/mch/index.htm
- Direct data sites for: MUA/HPSA data: http://www.bphc.hrsa.gov/bphc/database.htm
- Health data: http://www.in.gov/isdh/dataandstats/data_and_statistics.htm
- Poverty data: http://www.stats.indiana.edu/welfare_topic_page.html
- "Best Practice" guidelines for pregnant women: http://www.indianaperinatal.org
- County Fact Sheets with MCSHC Priority Counties:
  http://www.in.gov/isdh/programs/mch/countydatasheet.htm
- National Center for Cultural Competence: http://gucchd.georgetown.edu/nccc/index.html
- Indiana Department of Administration list of Minority owned Business Enterprises:
  http://www.in.gov/idoa/minority/Certifications.xls

Priority Health Needs for the MCSHC population, 2006-2011

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality, and racial and ethnic disparities in pregnancy outcomes. (ISDH Priorities #1 & #3)

2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families. (ISDH Priorities #1, #3, & #4)

3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors. (ISDH Priorities #1, #2, & #3)

4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects. (ISDH Priorities #1, #2, #3 & #4)

5. To decrease tobacco use in Indiana, particularly among pregnant women. (ISDH Priorities #1, #2, & #3)

6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs. (ISDH Priorities #1 & #3)

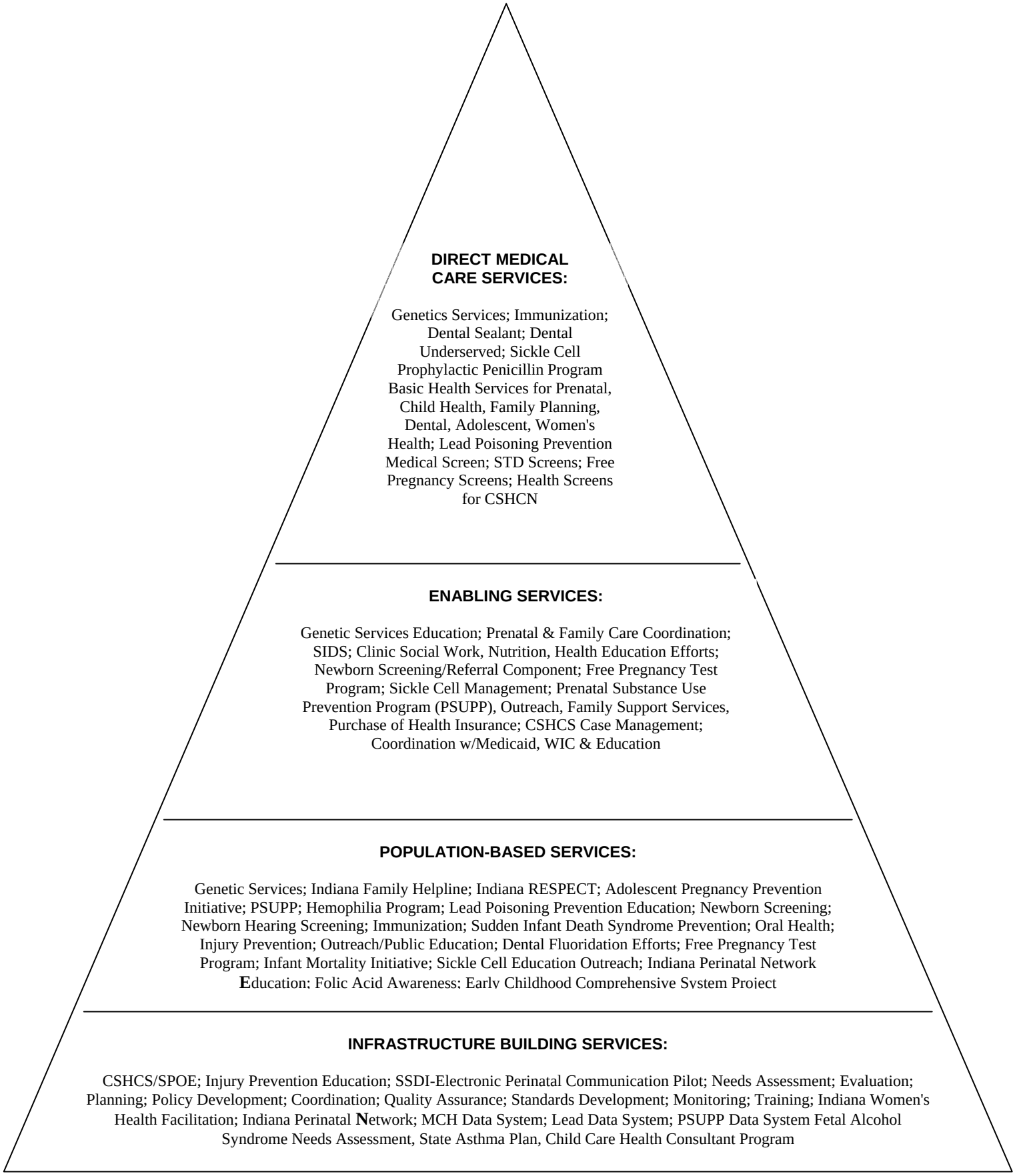
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity. (ISDH Priorities #1, #2, & #3)

8. To reduce obesity in Indiana. (ISDH Priorities #1, #2, & #3)

9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana. (ISDH Priorities #1 & #3)

10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes. (ISDH Priorities #1 & #3)

FIGURE 2: CORE PUBLIC HEALTH SERVICES



FY 2008 and FY 2009 CSHCS Grant Application Guidance

1. Applicant Information Page (Form A)

This is the first page of the proposal. **Complete all items on the page provided (Form A)**. The project director, the person authorized to make legal and contractual agreements for the applicant agency must sign and date this document.

2. Table of Contents

The table of contents must indicate the page where each section begins, including appendices.

3. CSHCS Proposal Narrative

A. Summary

Begin this page with the Title of Project as stated on the Applicant Information Page. The summary will provide the reviewer a succinct and clear overview of the proposal. The summary should:

- Relate to Children's Special Health Care Services program services only;
- Identify the problem(s) to be addressed;
- Succinctly state the objectives;
- Include an overview of solutions (methods);
- Emphasize accomplishments/progress made toward previously identified objectives and outcomes; and
- Indicate the percentage of the target population served by your project and the percentage of racial/ethnic minority clients among your clients served.

B. Forms B-1 and B-2

All information on the CSHCS Project Description (Form B) must be completed. Indicate how many clients will be served for FY 2008 and FY 2009. This summary form with its narrative will become part of the grant agreement and will also be used as a fact sheet on the project. Form B-2 requests specific information on each clinic site. The following information should be included:

- Project Description section must the history of the project, problems to be addressed, and a summary of the objectives and work plan. Any other information relevant to the project may also be included.
- CSHCS-Target population and estimated number to be served on Form B-2 is for the individual clinic site(s) and is the number to be served with CSHCS and CSHCS matching funds.
- CSHCS budget for site is the estimated CSHCS and CSHCS matching funds budgeted for the individual clinic site.
- Services provided in CSHCS budget site should include only those services provided with CSHCS and CSHCS matching funds.
- Other services provided at site should include all services offered at clinic site other than CSHCS and CSHCS matching funded services.

4. Applicant Agency Description

Note: Large organizations should write this description for the unit directly responsible for administration of the project.

This description of the sponsoring agency should:

- Identify strengths and specific accomplishments pertinent to this proposal;
- Include a discussion of the administrative structure within which the project will function within the total organization. Attach an organization chart;
- Identify project locations and discuss how they will be an asset to the project; and
- Include a discussion on the collaboration that will occur between the project and other organizations and healthcare providers. The discussion should identify the role of other collaborative partners and specify how each collaborates with your organization. You may attach MOU's, MOA's, and letters of support.

5. Statement of Need

Describe the specific problem(s) or need(s) to be addressed by the project. This section must address those CSHCS priority components that you intend to impact. These priority components are:

1. Family/professional partnership at all levels of decision-making.
2. Access to comprehensive health and related services through the medical home.
3. Early and continuous screening, evaluation and diagnosis.
4. Adequate public and/or private financing of needed services.
5. Organization of community services so that families can use them easily.
6. Successful transition to all aspects of adult health care, work, and independence.

- Clearly address how your program will address any or all of these priority components;
- Provide supporting data to document the need;
- Describe the system of care and how successfully the project fits into the system (identify the public service providers and the number of private providers in the area serving the same population with the same services and indicate a need for the project);
- Describe the target population(s) and numbers to be served and identify catchment areas;
- Describe how the program will be client/consumer focused; and
- Describe barriers to access to care.

6. Outcome and Performance Objective's and Activities

Applicants are to complete one Objectives, Activities, and Evaluation form for each service provided. Project specific activities will be evaluated as part of the quality evaluation of the project.

These forms are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Report for FY 2008 when it is completed. CSHCS consultants will contact projects quarterly to monitor progress on the activities and provide technical assistance.

All applicants are required to collect data for monitoring purposes. Monitoring data elements requirements should be proposed by the applicant based on the services to be provided and will be finalized in the grant agreement. This information will be reported in the FY 2008 Annual Performance Reports.

REQUIRED FORMS FOR SPINA BIFIDA PROGRAMS

1) Form A: Applicant Information

2) Form B1 and B2: CSHCS Project Description

3) Form C: Funding Currently Received by Your Agency from ISDH

4) Performance Measures 1 - 4

Note: *Providers serving counties with significant numbers of minority populations must identify activities for Performance Measures 1 and 3 related to outreach and marketing to the minority populations to provide culturally competent services to those populations.*

Indiana State Department of Health
Spina Bifida Programs

FY 2008 Performance Measures

Performance Measure 1: Provide evaluation and counseling services in designated area(s).

Performance Objective 1:
☐ ***Increase*** the number of patients receiving services by _____%.
☐ ***Maintain*** the number of patients receiving services.

Service Projections

Directions- Give estimates for current and upcoming years for the total number of patients. For FY 2006, state the number of patients seen for each of the types of services listed below. ***FY 2007 numbers should be the same as your FY 2007 application. FY 2008 and FY 2009 should be numbers that reflect the percentage increase that you have set as a goal in the Performance Objective.*** Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in the annual report. Grayed in areas will be filled in on the quarterly and annual reports, **do not** fill them in at this time. Please see **Services Definitions** on page 57 for more information concerning types of services.

Clinical Patients

	# of Patients			
Type of Service	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Evaluation/Counseling- Patient is an infant <1 year of age				
Evaluation/Counseling- Patient is a child >1 year of age but <22 years of age				
Evaluation/Counseling- Patient is ≥22 years of age				
Counseling Only				
Consultations				
Total				

Supporting Activities Table

Directions- State the planned activities to increase the number of patients receiving genetic services and which staff members will be responsible for those activities. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children under 3 years of age are informed about First Steps.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families are informed about Children's Special Health Care Services (CSHCS)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families with children <5 years of age are informed about Women, Infants, and Children (WIC) clinic		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Spina Bifida Programs

FY 2008 Performance Measures

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

(Please report the following percentages in the subsequent tables.)

Performance Objective 2a: _____% women of childbearing age, seen in clinic, will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

Performance Objective 2b: _____% women of childbearing age, seen in clinic, will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

Performance Objective 2c: _____% women of childbearing age, seen in clinic, will be educated to the ***positive*** effects of taking ***folic acid***.

Service Projections

Directions- We expect that at least **90%** of women of childbearing age, seen in clinic, will be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid. Give estimates for current and upcoming years for each of the types of services listed below. Please give actual numbers and percentages for 2006. Only complete for patients in your project population. Grayed in areas will be filled in on the quarterly and annual reports, **do not** fill them in at this time.

PO 2a: Women of childbearing age seen in clinic and educated to the *negative* effects of *smoking* during pregnancy

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who smoke and were seen in clinic, that received **smoking cessation education**				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic, that received **smoking cessation education**				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking *folic acid*

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who were seen in clinic and received **folic acid education**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received **folic acid education**				

Directions- State which staff members will be responsible for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid preconception or had smoked and/or consumed alcohol during pregnancy.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients who admit to smoking, drinking or using drugs and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist are informed about PSUPP.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Spina Bifida Programs

FY 2008 Performance Measures

Performance Measure 3: Provide educational presentations to health professionals and the general public.

Performance Objective 3: *(Please report the following numbers in the subsequent table.)*

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers.

Service Projections

Directions- A ***minimum of 4*** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals. Give estimates for current and upcoming years for each of the types of presentations listed below. Please give actual numbers for 2006. While a **minimum** of 4 talks is required, please try to give accurate estimates based on the 2007 application. For upcoming years, please realistically project how many talks you might be providing. When the audience is mixed count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences. Please see **Services Definitions** on page 57 for more information concerning types of audiences.

Genetics Presentations

	# of Talks			
Main audience:	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
General Public *(e.g. high school students, support groups, etc.)*				
Health care professionals and college or graduate level students				
Total				

Supporting Activities Table

Directions- State which staff members will be responsible for the following activity. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Evaluation sheets will be collected for each talk.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Audience size will be counted at each talk. (**Note**: attendance or evaluation sheets may be used to determine these numbers)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Note: Evaluation narrative should include a sample evaluation sheet and a description of how scores will be compiled.

Indiana State Department of Health
Spina Bifida Programs

FY 2008 Performance Measures

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Service Projections

Directions- Give estimates for current and upcoming years of the **total** number of children <3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future**. Grayed in areas will be filled in on the quarterly and annual reports, **do not** fill them in at this time. A list of reportable conditions and PDF version of the reporting form can be found at http://www.in.gov/isdh/programs/ibdpr/reporting.htm.

Reporting to the IBDPR

	# of Patients			
	FY 2006 (Baseline)	**FY 2007**	**FY 2008**	**FY 2009**
Number of children <3 years of age* with at least 1 reportable birth defect that **were** reported to the IBDPR				
Total number of children <3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*or up to 5 years of age for autism or FAS

Supporting Activities Table

Directions- State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Complete a report form for each patients less than 3 years of age (5 years for autism or FAS) that are born with a reportable condition and then fax the form to ISDH.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Spina Bifida Programs

FY 2008 Performance Measures

Project Specific Performance Measure:

Project Specific Performance Objective :

Service Projections

	FY 2006 (Baseline)	FY 2007	FY 2008	FY 2009

Supporting Activities Table

Directions- State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

BUDGET INSTRUCTIONS

Materials Provided: The following materials are included in this packet:

Instructions
Definitions-Revenue Accounts
Chart of Account Codes
Non-allowable Expenditures
Budget Narrative Form (CSHCS Budgets for FY 2008 & FY 2009)
Section I - Sources of Anticipated Revenue (CSHCS Budgets for FY 2008 & FY 2009)
Section II - Estimated Costs and Clients to be Served (CSHCS Budgets for FY 2008 & FY 2009)
Anticipated Expenditures (CSHCS Budgets for FY 2008 & FY 2009)

INSTRUCTIONS

Review all materials and instructions before beginning to complete your budget. If you have any questions relative to completing your project's budget, contact:

Robert Bruce Scott	**rbscott@isdh.in.gov**	**317/233-1241**
Or		
Bob Bowman	**bobbowman@isdh.in.gov**	**317/233-1231**

In completing the packet, remember that all amounts should be rounded to the nearest dollar.

Completing the Budget Narrative Form

NOTE: Create a separate budget for Fiscal Year (FY) 2008 and for FY 2009. FY 2008 runs July 1, 2007 through June 30, 2008. FY 2009 runs July 1, 2008 through June 30, 2009.

The Budget Narrative Form does not provide a column for CSHCS Matching Funds but does provide a column for Total CSHCS + CSHCS Matching.

Schedule A
For each individual staff, provide the name of the staff member and a brief description of their role in the project. If multiple staff are entered in one row (for instance, 111.400 Nurses) a single description may be provided if applicable. Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column. This calculation should be in the form $salary = $/hr. X hours per week X weeks per year. Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, Fringe may be calculated by category.

Schedule B
List each contract, each piece of equipment, general categories of supplies (office supplies, medical supplies, etc.), travel by staff member, and significant categories in Other Expenditures (such as Indirect) in the appropriate column. Provide calculations as appropriate. Calculations are optional for Contractual Services. Travel must be calculated for each staff member who will be reimbursed and may not exceed $0.40 per mile.

Completing Section I - Sources of Anticipated Revenue

List all anticipated revenue according to source. If the project was funded in previous years with Children's Special Health Care Services funds, estimate the cash you expect to have available from the previous year. This estimated cash-on-hand should be indicated by 400.1 and/or 400.2, respectively. If the estimated cash balance is negative, please list the estimate as $0. All revenue used to support the project operations must be budgeted.

Projects must include matching funds equaling a minimum of 30% of the CSHCS budget. **"In-kind" contributions are not to be included in the budget. Projects that cannot meet these requirements must provide written justification in the budget narrative.** Matching funds are subject to the same guidelines as CSHCS funds (i.e., no equipment, food, entertainment or legislative lobbying). Costs of a modem line for each of your CSHCS computers and costs of Internet access are allowable.

Non-matching funds are additional sources of support that are not included in the match. These funds are not subject to CSHCS guidelines. ***Hint: Do not overmatch. Funds supporting the program that are above the minimum 30% match requirement may be listed as "Other Nonmatching"***.

In the space at the bottom of Section I, please be sure to indicate how many hours are worked in a "normal" work week. This is usually determined by the applicant agency's policies.

Completing Section II - Estimated Cost and Clients to be Served

It is essential that this form be completed accurately because the information will be used in your contract. Your project will be accountable for the services that are listed and the number estimated to be served.

Estimate the CSHCS Cost per Service listed e.g. how much of your CSHCS grant you propose to expend in each service. Figures for this, by service category, are listed in the column entitled "**CSHCS COST PER SERVICE"**. The total at the bottom of this column should equal the MCH grant award request.

Estimate the CSHCS Matching Funds allocated per service listed e.g., how much of the CSHCS match you propose to expend in each service. The total at the bottom of this column should equal the total match you are adding to the CSHCS award to fund this program.

Estimate the number of unduplicated clients by service category who will receive each service in the column titled **"TOTAL UNDUPLICATED # ESTIMATED TO BE SERVICED"** by both CSHCS and CSHCS Matching Funds.

(The rest of this page left blank intentionally)

DEFINITIONS - REVENUE ACCOUNTS

Account	Account Title	Description
414	CSHCS Grant Request	Funds requested as reimbursement from the Indiana State Department of Health for project activities.
Matching Funds*		*Cash used for project activities that meet the matching requirements and are designated by the project as matching funds.* *****
417	Local Appropriations	Monies appropriated from the local government to support project activities, e.g., local health maintenance fund.
419	First Steps	Monies received from First Steps for developmental disabilities services.
421	Donations – Cash	Monies received from donors to support project activities.
424	United Way/March of Dimes	Monies received from a United Way/March of Dimes agency to support project activities.
432	Title XIX – Hoosier Heathwise and Title XXI, CHIP	Monies received from Hoosier Heathwise and CHIP as reimbursement provided for services to eligible clients.
434	Private Insurance	Monies received from health insurers for covered services provided to participating clients.
436	Patient Fees	Monies collected from clients for services provided based on CSHCS approved sliding fee schedule.
437	Other Matching	Other income directly benefiting the project and not classified above which meets matching requirements.
Nonmatching Funds		*Funds which do not meet matching requirements or are not designated as matching funds.*
433	Title XX	Monies received from State Title XX agency (Family and Social Services Administration) for reimbursement provided for family planning services to eligible clients.
439	Other Nonmatching	Income directly benefiting the project and not classified above that does not meet matching requirements or that is in excess of the required/ designated match amount.
Estimated Cash on Hand as of June 30, of last FY		*Monies received by the project during the previous fiscal years and not yet used for project expenditures.*
400.1	Matching Cash on Hand	Those monies received during previous years from sources classified as matching.
400.2	Nonmatching Cash on Hand	Those monies received during previous years from sources classified as nonmatching.

***** Matching requirements include:

1. Amounts are verifiable from grantee's records.
2. Funds are not included as a matching source for any other federally assisted programs.
3. Funds are allocated in the approved current budget.
4. Funds are spent for the CSHCS project as allocated and the expenditure of these funds is reported to CSHCS Services.
5. Funds are subject to the same expenditure guidelines as CSHCS grant funds (i.e., no food, entertainment or legislative lobbying).

SCHEDULE A - CHART OF ACCOUNT CODES

111.000 PHYSICIANS

- Clinical Geneticist
- Family Practice Physician
- General Family Physician
- Genetic Fellow
- Medical Geneticist
- Neonatologist
- OB/GYN
- Other Physician
- Pediatrician
- Resident/Intern
- Substitutes/Temporaries
- Volunteers

111.150 DENTISTS/HYGIENISTS

- Dental Assistant
- Dental Hygienist
- Dentist
- Substitutes/Temporaries
- Volunteers

111.200 OTHER SERVICE PROVIDERS

- Audiologist
- Child Development Specialist
- Community Educator
- Community Health Worker
- Family Planning Counselor
- Genetic Counselor (M.S.)
- Health Educator/Teacher
- Occupational Therapist
- Outreach Worker
- Physical Therapist
- Physician Assistant
- Psychologist
- Psychometrist
- Speech Pathologist
- Substitutes/Temporaries
- Volunteers

111.350 CARE COORDINATION

- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Physician
- Registered Dietitian
- Registered Nurse
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

111.400 NURSES

- Clinic Coordinator
- Community Health Nurse
- Family Planning Nurse Practitioner
- Family Practice Nurse Practitioner
- Licensed Midwife
- Licensed Practical Nurse
- OB/GYN Nurse Practitioner
- Other Nurse
- Other Nurse Practitioner
- Pediatric Nurse Practitioner
- Registered Nurse
- School Nurse Practitioner
- Substitutes/Temporaries
- Volunteers

111.600 SOCIAL SERVICE PROVIDERS

- Caseworker
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Counselor
- Counselor (M.S.)
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitutes/Temporaries
Nutritionist (Master Degree)	Volunteers

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitutes/Temporaries
Genetic Associate/Assistant	Volunteers
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel (only available with non-matching funds)
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	Insurance premiums for fire, theft, liability, fidelity bond Malpractice insurance premiums cannot be paid with funds. However, matching and nonmatching funds c used.
Maintenance and Repair --	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project cost for CSHCS projects and may not be paid for with CSHCS or CSHCS Matching Funds:

1. Construction of buildings, building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase / rental;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Client travel; and
15. Legislative lobbying.

The following may be claimed as project cost for CSHCS projects and may be paid for only with specific permission from the Director of Maternal and Children's Special Health Care Services, ISDH:

1. Equipment;
2. Out-of-state travel; and
3. Dues to societies, organizations, or federations.

All equipment costing $1,000 or more that is purchased with CSHCS and/or CSHCS Matching Funds, shall remain the property of the State and shall not be sold or disposed of without written consent from the State.

For further clarification on allowable expenditures please contact:

Robert Bruce Scott, Grants Coordinator, MCSHC, rbscott@isdh.in.gov 317/233-1241

FY 2008 Budget Narrative

The budget narrative must include a justification for every CSHCS line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the CSHCS budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement ($.40 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total CSHCS	Total CSHCS + CSHCS MATCHING
	For each personnel entry, include name, title and brief description of their role in the project (i.e. Provides Direct Services) List all appropriate staff in the box provided. If there are 4 Nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to CSHCS	Total cost charged to CSHCS and CSHCS Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total MCH	Total CSHCS + CSHCS MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = $0.40 X miles for each staff being reimbursed for travel.	Total to be charged to CSHCS	Total cost charged to CSHCS and CSHCS Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

FY 2009 Budget Narrative

The budget narrative must include a justification for every CSHCS line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the CSHCS budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement ($.40 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total MCH	Total MCH + MCH MATCHING
	For each personnel entry, include name, title and brief description of their role in the project (i.e. Provides Direct Services) List all appropriate staff in the box provided. If there are 4 Nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to CSHCS	Total cost charged to CSHCS and CSHCS Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total CSHCS	Total CSHCS + CSHCS MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = $0.40 X miles for each staff being reimbursed for travel.	Total to be charged to CSHCS	Total cost charged to CSHCS and CSHCS Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2008

Project Title: _____ Project # _____

Applicant Agency: _____

413 Maternal and Children's Special Health Care Services Grant Request

(A) $_____

MATCHING FUNDS - CASH

417	Local Appropriations	$_____
419	First Steps	$_____
421	Cash Donations	$_____
424	United Way/March of Dimes	$_____
432	Hoosier Heathwise/CHIP (Titles XIX / XXI)	$_____
434	Private Insurance	$_____
436	Patient Fees	$_____
437	Other Matching	$_____

TOTAL MATCHING FUNDS (Cash) (B) $_____

NONMATCHING FUNDS - CASH

433	Title XX	$_____
439	Other	$_____

TOTAL NONMATCHING FUNDS (C) $_____

ESTIMATED CASH ON HAND AS OF June 30, 2007

400.1	Matching	$_____
400.2	Nonmatching	$_____

TOTAL ESTIMATE (400.1 + 400.2) (D) $_____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) $_____

A Full-Time Employee Works _____ Hours Per Week.

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2009

Project Title: _____ Project # _____

Applicant Agency: _____

414 Maternal and Children's Special Health Care Services Grant Request (A) $_____

MATCHING FUNDS - CASH

417	Local Appropriations	$_____
419	First Steps	$_____
421	Cash Donations	$_____
424	United Way/March of Dimes	$_____
432	Hoosier Heathwise/CHIP (Titles XIX / XXI)	$_____
434	Private Insurance	$_____
436	Patient Fees	$_____
437	Other Matching	$_____

TOTAL MATCHING FUNDS (Cash) (B) $_____

NONMATCHING FUNDS - CASH

433	Title XX	$_____
439	Other	$_____

TOTAL NONMATCHING FUNDS (C) $_____

ESTIMATED CASH ON HAND AS OF June 30, 2008 (may use estimate for 2007)

400.1	Matching	$_____
400.2	Nonmatching	$_____

TOTAL ESTIMATE (400.1 + 400.2) (D) $_____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) $_____

A Full-Time Employee Works _____ Hours Per Week.

SECTION II - BUDGET
CSHCS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2008

Project Title:_____ Project #_____

Applicant Agency: _____

Service	CSHCS Cost Per Service[1]	CSHCS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by CSHCS & CSHCS Matching Funds[5]
Spina Bifida Coordination of Medical/ Community Services			
Spina Bifida School Planning Assistance			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the CSHCS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from CSHCS Budget – 1).

3 Cells in this column should reflect the amount of CSHCS matching funds estimated to be spent on specific services.

4 This cell should reflect total CSHCS matching funds estimated to be spent on CSHCS services (line B from CSHCS Budget –1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with CSHCS and CSHCS matching funds during the fiscal year.

SECTION II - BUDGET
CSHCS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2009

Project Title:_____ Project #_____

Applicant Agency: _____

Service	CSHCS Cost Per Service[1]	CSHCS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by CSHCS & CSHCS Matching Funds[5]
Spina Bifida Coordination of Medical/ Community Services			
Spina Bifida School Planning Assistance			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the CSHCS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from CSHCS Budget – 1).

3 Cells in this column should reflect the amount of CSHCS matching funds estimated to be spent on specific services.

4 This cell should reflect total CSHCS matching funds estimated to be spent on CSHCS services (line B from CSHCS Budget –1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with CSHCS and CSHCS matching funds during the fiscal year.

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2008

Project Title: _____ Project #_____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project[1]
			CSHCS Funds 413	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
	Schedule A															
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
	Schedule B															
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

[1] Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2009

Project Title: _____ Project #_____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project[1]
			CSHCS Funds 413	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
	Schedule A															
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
	Schedule B															
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

[1] Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

FORM A

CHILDREN'S SPECIAL HEALTH CARE SERVICES
GRANT APPLICATION
FY 2008 & FY 2009

Title of Project _____ Federal I.D. # _____

Medicaid provider Number: _____ FY 2007 CSHCS Contract Amount $_____

FY 2008 MCH Amount Requested: $_____ FY 2008 Matching Funds Contributed $_____

FY 2009 MCH Amount Requested: $_____ FY 2009 Matching Funds Contributed $_____

Legal Agency /Organization Name: _____

_____

Street City Zip Code

_____ _____ _____

Phone FAX E-Mail Address

_____ _____ _____

Project Director (type name) Phone E-Mail Address

_____ _____

Board President/Chairperson (type name) Phone

_____ _____

Project Medical Director (type name) Phone

_____ _____ _____

Agency CEO or Official Custodian of Funds (type name) Title Phone

_____ _____

Signature of Project Director Date

_____ _____ _____

Signature of person authorized to make legal And contractual agreement for the applicant agency Title Date

_____ _____ _____

Signature of County Health Officer (or date letter sent to County Health Officers) County Date

Are you registered with the Secretary of State? ☐ Yes ☐ No

Note: All arms of local and State government are registered with the Secretary of State. Applicants must be registered with the Secretary of State to be considered for funding.

FORM B-1

FY 2008 & FY 2009
Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	E-Mail Address
Counties Served:		
Type of Organization: State ☐	Local ☐	Private Non-Profit ☐
Requested Funds: $_____ Matching Funds: $_____ Non-matching Funds: $_____ (Amounts above should reflect totals for FY 2008 + Total for FY 2009)		
Sponsoring Agency:		
Summarize identified needs from the needs assessment section. Include only those needs the Project will address.		
Summarize Performance Measures from Performance Measures Tables {hint: each identified need above should be addressed with a Performance Measure}		

FY 2008 & FY 2009

FORM B-2

CSHCS Project Name:	Project Number:	# Clinic Sites

Clinic Site Address:	Clinic Schedule: (days & times)	CSHCS Budget for Site (include matching funds):
Counties Served:	Services Provided in CSHCS Budget for site (include matching funds):	
Target Population and estimated number to be served with CSHCS and matching funds:	Other services provided at site (non-CSHCS or non-Match):	
Clinic Site Address:	Clinic Schedule: (days & times)	CSHCS Budget for Site (include matching funds):
Counties Served:	Services Provided in CSHCS Budget for site (include matching funds):	
Target Population and estimated number to be served with CSHCS and matching funds:	Other services provided at site (non-CSHCS or non-Match):	
Clinic Site Address:	Clinic Schedule: (days & times)	CSHCS Budget for Site (include matching funds):
Counties Served:	Services Provided in CSHCS Budget for site (include matching funds):	
Target Population and estimated number to be served with CSHCS and matching funds:	Other services provided at site (non-CSHCS or non-Match):	
Clinic Site Address:	Clinic Schedule: (days & times)	CSHCS Budget for Site (include matching funds):
Counties Served:	Services Provided in CSHCS Budget for site (include matching funds):	
Target Population and estimated number to be served with CSHCS and matching funds:	Other services provided at site (non-CSHCS or non-Match):	
Clinic Site Address:	Clinic Schedule: (days & times)	CSHCS Budget for Site (include matching funds):
Counties Served:	Services Provided in CSHCS Budget for site (include matching funds):	
Target Population and estimated number to be served with CSHCS and matching funds:	Other services provided at site (non-CSHCS or non-Match):	

FORM C

FUNDING **CURRENTLY** RECEIVED BY YOUR AGENCY
FROM THE INDIANA STATE DEPARTMENT OF HEALTH

LIST ALL SOURCES OF ISDH FUNDING

SOURCE	FISCAL YEAR	AMOUNT

TOTAL $_____

COMMENTS:

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES
SPINA BIFIDA PROGRAMS
ANNUAL PERFORMANCE REPORT FY 2008

PROJECT NAME: _____

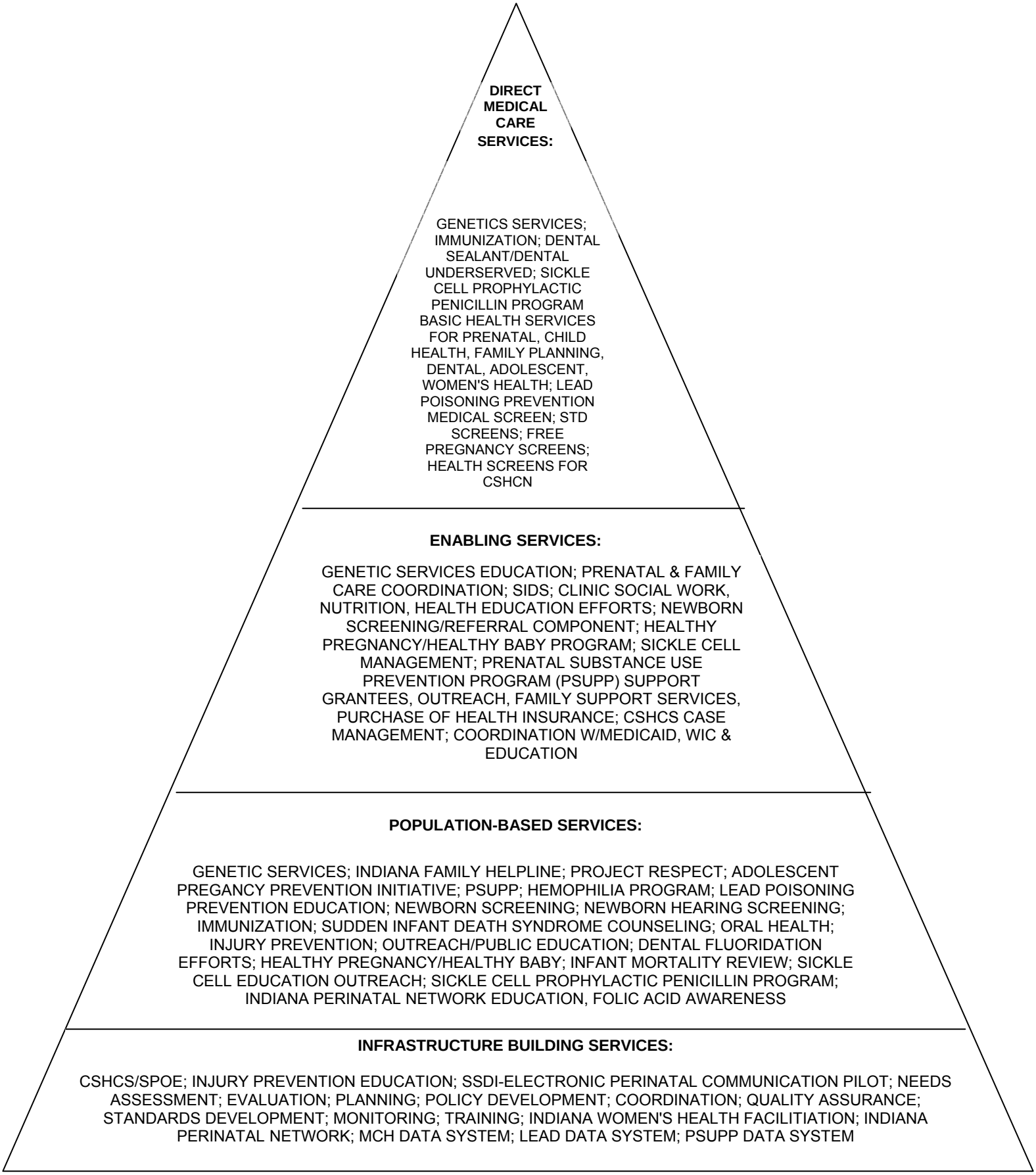
PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2008 (7/1/07 TO 6/30/08)

DATE SUBMITTED: _____ PREPARED BY: _____

FIGURE1: CORE PUBLIC HEALTH SERVICES DELIVERED BY CSHCS AGENCIES



I. Instructions

Instructions are included by section in the report form.

II. Narrative

Using the categories below, describe through narrative and statistics the services provided by CSHCS funding to women and/or children in your project during the last fiscal year. Keep the discussion brief and address only the services and activities in which your project is engaged and which are funded by CSHCS funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your CSHCS program including where your services fit into the Core Public Health Services Pyramid. As part of the description of services provided, the discussion should include the following information for each service category:

- Explain the strengths and weaknesses of the project and project accomplishments during the funding year.
- Explain any significant discrepancies between projected number served and actual number served. Significant discrepancies exist if the number served fell below or exceeded projected service levels by more than 10%.
- Explain any change in clinical or administrative procedure, including staffing changes.
- Document activities to improve communications with, outreach to and services for racial and ethnic minorities. Include plans to reduce disparities in access to services and health outcomes.
- Complete the hours of services form. Indicate any changes from the original application.
- List which agencies and organizations are cooperating with the project and explain their role. **All** indicated agencies and organizations should have current MOUs with the project.
- Elaborate on special events and initiatives undertaken by the project in the Work Plan Activities listed on the Performance Measure Tables Work Plans.

III. Quality Assurance

1. Chart Audit. If the Project served less than 200 clients, review 50 charts or all charts of clients served (whichever # is less annually). If the Project served 200 or more clients, review 100 charts. **Summarize the findings and indicate changes or improvements to be made.** The project should conduct 25% of the annual chart reviews during each quarter during the funding year and described in the quarterly reports along with either adaptations and changes or adjustments made in the work plan or policies and procedures as a result of the chart review findings.

2. Review the CSHCS data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine if staff completion or errors is the problem.

3. Report appropriate individuals to the IBDPR. Document every child with a birth defect that was seen in the Project clinic and verify that the child is reported to the Indiana Birth Defects and Problems Registry provided the patient is within the appropriate age range.

4. Send a copy of the chart audit tool format used for each service type.

IV. Demographic Data

Complete Tables 1-4. This information is essential for Maternal and Child Health Services to meet federal reporting requirements.

Table 1. Number of New Individuals Who Received Services, Fiscal Year 2008, by Race

Class of individual and type of service	# Est. to be Served*	Race							Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS >22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2008/2009 proposal.
**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Services, Fiscal Year 2008, by Race

Class of individual and type of service	# Est. to be Served*	Race							Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS >22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2008/2009 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by CSHCS or CSHCS Matching Funds, Fiscal Year 2008, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMAN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

Table 4. Number of Return Visit Individuals Who Received Services Provided or Paid for in Whole or in Part by CSHCS or CSHCS Matching Funds, Fiscal Year 2008, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMAN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

V. Program Monitoring Data

Tables 5 - 12 request program monitoring data.

Table 5: Types of Service Provided

Type of Service	Pregnant Women	Infants <1 Year of Age	Children Under 22 (Excluding Those <1 yr)	Patients ≥22 years of age	Total
Pre-Diagnosis Counseling					
Post-Diagnosis Counseling					
Evaluation/Counseling for a **known** diagnosis					
Evaluation/Counseling for an **unknown** diagnosis					
Counseling Only					
Consultations					
Telephone Contacts					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals To CSHCS					
Referrals To PSUPP					
Referrals To WIC Clinic					

*only if applicable.

See **Definitions** in Appendix 2 for clarification of the types of services.

Table 6: Educational Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
General Public (e.g. high school students, support groups, etc.)			
Health care professionals and college or graduate level students			
Other Presentations			
TOTAL			

NOTE: The number of educational sessions should match the number given in the grant application. Additional information required in the Performance Measures section.

Table 7: Patient Satisfaction Surveys

	Number of Surveys Given to Clients	Number of Surveys Completed and Returned	Survey Return Rate	Score for Scheduling and Location	Score for Interaction with Clinic Staff	Score for Expectations and Understanding	Score for Benefits of Genetics Clinic	Score for Overall Satisfaction
Prenatal Services								
Clinical Services								
TOTAL								

Table 8: Primary Indication for Reason for Referral to Clinical Services

	FY 06	FY 07	FY 08
1. Rule Out/Confirm or Make Specific Diagnosis			
2. Return Visit (returning to same project group)			
3. Follow-up Appointment for Diagnosis made by an Unaffiliated Provider			
4. Unknown Reason for Referral			
TOTAL			

Table 9: Final or Best Working Diagnosis for Clinical Patients

	FY 06	FY 07	FY 08
1. No Evidence of Abnormality or Specific Disorder			
2. Chromosomal and Single Gene Disorders			
3. Metabolic/Endocrine			
4. Neuromuscular			
5. Skeletal/Connective Tissue/Neural Ectodermal (Excluding Chromosomal)			
6. Hematologic			
7. Functional Disorders			
8. Single Malformation			
9. Reproductive Risks (Use only when none of the above apply)			
10. Multiple Congenital Anomalies/Multiple Malformation Syndrome			
11. Unknown			
TOTAL			

Note: See Appendix 3 for examples of ***Final or Best Working Diagnosis*** for each option.

Table 12: Unduplicated Patients Seen By County of Residence

COUNTY	PREGNANT WOMEN	CLINICAL PATIENTS	**TOTAL**
TOTAL			

VI. Project Data

Specific directions are stated for each Performance Measure. Indicate if the Performance Objective was met by checking Yes or No. A Performance Objective Summary of all services is provided in Appendix 1. Please complete the summary for all services provided by the project.

FY 2008 Objectives should be completed based upon the projections submitted in the FY 2008 grant application.

The specific activities for each objective should be completed and the status of each indicated in the Comments/TA Plans section. If objectives were not met, indicate in this column why they were not met and what action will be taken to meet them this year. Your consultant will use this section to monitor project activities and provide technical assistance. Some forms have specific activities already listed. The status of each should be indicated as well as any additional comments. Any additional activities for your project should be listed. (See Appendix 2 for additional instructions and definitions).

Genetic Service Providers should complete the following pages addressing CSHCS performance measures.

A. Spina Bifida

Performance Measure 1: Provide evaluation and counseling services in designated area(s).

Performance Objective 1:
☐ ***Increase*** the number of patients receiving services by _____%.
☐ ***Maintain*** the number of patients receiving services.

Directions- Report the total number of patients seen in your project population. The estimated number of patients is the number submitted on the grant application. Grayed in areas do not need to be completed.

Clinical Patients

# of Patients	FY 2006	FY 2007	FY 2008	FY 2009
Total Number of Patients Seen				
Estimated Number of Patients Seen				
Percent of Estimate Achieved				

Percent of Estimate Achieved = [Number of Patients Seen / Estimated Number of Patients Seen] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Directions- State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that aided in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children under 3 years of age were informed about First Steps.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families were informed about Children's Special Health Care Services (CSHCS)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families with children <5 years of age were informed about Women, Infants, and Children (WIC) clinic		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Spina Bifida

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Performance Objective 2a: _____% women of childbearing age, seen in clinic, will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

Performance Objective 2b: _____% women of childbearing age, seen in clinic, will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

Performance Objective 2c: _____% women of childbearing age, seen in clinic, will be educated to the ***positive*** effects of taking ***folic acid***.

Service Projections

Directions- Report the number of patients seen in your project population and from these numbers calculate the corresponding percentages. We expect that at least **90%** of women of childbearing age, seen in clinic, will be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

PO 2a: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *smoking* during pregnancy

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who smoke and were seen in clinic, that received **smoking cessation education**				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic, that received **smoking cessation education**				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking *folic acid*

	FY 2006	FY 2007	FY 2008	FY 2009
Number of women of childbearing age who were seen in clinic and received **folic acid education**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received **folic acid education**				

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Directions- State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid or had smoked and/or consumed alcohol during pregnancy.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients who admit to smoking, drinking or using drugs and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist were informed about PSUPP.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Spina Bifida

Performance Measure 3: Provide educational genetics presentations to health professionals and the general public.

Performance Objective 3:

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers.

Directions- Report the total number of presentations given by your project staff. A ***minimum of 4*** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals. Calculate the Percent Completed only for the current year. In terms of estimating audience size, when the audience is mixed, count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences.

	# of Talks						
Main audience:	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2008 Estimated**	***FY 2008 % Completed***	**FY 2009 Actual**	**FY 2009 Estimated**	***FY 2009 % Completed***
General Public (e.g. high school students, support groups, etc.)							
Health care professionals and college or graduate level students							
Other Presentations							
Total							

Percent completed = [Number of talks given / Estimated number of talks] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Directions- State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Evaluation sheets will be collected for each talk.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Audience size will be counted at each talk. (**Note**: attendance or evaluation sheets may be used to determine these numbers)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Spina Bifida

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Directions- Report the **total** number of children <3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future**. A list of reportable conditions and PDF version of the reporting form can be found at http://www.in.gov/isdh/programs/ibdpr/reporting.htm.

Reporting to the IBDPR

	# of Patients			
	FY 2006 (Baseline)	**FY 2007**	**FY 2008**	**FY 2009**
Number of children <3 years of age* with at least 1 reportable birth defect that **were** reported to the IBDPR				
Total number of children <3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*or up to 5 years of age for autism or FAS

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Directions- State the Activity Status and provide any Comments/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
Report form for each patients < 3 years of age (5 years for FAS and autism) that are born with a reportable condition is completed and faxed to ISDH.		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. Spina Bifida

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

	FY 2007	FY 2008	Percent Change from previous year

Percent change = [(2008 #s – 2007 #s) / 2007 #s] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. Spina Bifida

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2007	FY 2008	FY 2009
	%	%	%
	%	%	%
	%	%	%

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

Appendix 1

Spina Bifida Services
Performance Objective Summary
FY 2008 & FY 2009

FY 2008

	MET	
PERFORMANCE OBJECTIVE 1:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 3:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4:	☐ ***YES***	☐ ***NO***

Percent of CSHCS Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

Spina Bifida Services
DEFINITIONS
FY 2008 & FY 2009

Definitions are listed according to appearance in the application.

Tables 2 and 4

Return Visit Individuals – individuals that have been previously seen in your project clinic and are returning for follow-up care

Table 5

Clinical Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of occurrence of a disorder in a family. For reporting purposes this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (i.e. a physical examination) is performed in addition to genetic counseling services.

Performance Measure 3

College or graduate level students– includes nursing and medical students.

Appendix 3

Descriptions for Final or Best Working Diagnosis Table

(Five examples for each are listed.)

Chromosomal / Single gene
-cytogenetic and mutation analysis
1) Trisomies
2) 45, X
3) 47, XXY
4) Fragile X
5) 22q11.2 deletion

Metabolic / Endocrine
1) PKU
2) Galactosemia
3) Hypothyroid
4) Cystic Fibrosis
5) Tay-Sachs

Neuromuscular
1) Huntington disease
2) Muscular dystrophy
3) Mitochondrial disorders
4) Myasthenia gravis
5) Glycogen storage diseases

Skeletal / Connective Tissue
1) Marfan syndrome
2) Ehlers-Danlos syndrome
3) Tuberous sclerosis
4) Neurofibromatosis
5) Dysplasias

Hematologic
1) Hemophilia A
2) Other hemophilias
3) Alpha-thalassemia
4) Beta-thalassemia
5) Sickle cell anemia

Functional Disorders
1) Autism
2) Epilepsy
3) Cerebral palsy
4) Mental retardation
5) Failure to thrive / Growth retardation

Single Malformation
1) Limb
2) Anencephaly
3) Myelomeningocele
4) Cleft lip and/or palate
5) Heart defect

Reproductive Risk
1) Infertility
2) Consanguinity
3) Exposures
4) Known carrier
5) Increased empiric risk

Multiple Congenital Anomalies
1) CHARGE
2) VATER / VACTERL
3) MURCS
4) Pierre-Robin sequence
5) Potter sequence

Multiple Malformation
-when more than one malformation is present and the overall gestalt does not match any known association or syndrome or sequence.

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CSHCS DEFINITIONS
FY 2008 & FY 2009

Client/Patient – a recipient of services that are supported by program expenses funded in whole or in part by Children's Special Health Care Services (CSHCS) or local (CSHCS) matching dollars

Program Expenses – any expense included in the budget that the CSHCS project proposes to be funded by CSHCS or CSHCS matching dollars (includes staff, supplies, space costs, etc.)

Matching Funds – At least 30% of the CSHCS award. Whatever dollars the project assigns to support the CSHCS funded service (includes Medicaid or other income generated by service provision)

Types of Clients – pregnant women, infants, children, adolescents, adult women and families

CSHCS Supported Services –

- Direct medical and dental care: Family Planning, Prenatal Care, Child Health (infant, child adolescent), Women's Health,
- Enabling services: Prenatal Care Coordination, Family Care Coordination

These definitions will allow CSHCS projects to include all clients seen that are funded by CSHCS or CSHCS match dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with CSHCS or CSHCS matching funds.

Cultural Competence -
Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989)

Appendix B

Spina Bifida Services Definitions
FY 2008 & FY 2009

Definitions are listed according to appearance in the application.

Pages 14 and 15

Clinical Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of occurrence of a genetic disorder in a family. For reporting purposes this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Inpatient Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone Contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (i.e. a physical examination) is performed in addition to genetic counseling services.

Page 18

College or graduate level students– includes nursing and medical students.

INDIANA CSHCS SYSTEMS DEVELOPMENT CONSULTANT ASSIGNMENTS

Appendix C
INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GRANT APPLICATION SCORING TOOL

FY 2008 & FY 2009 CSHCS Application Review Score: _____

Applicant Agency: _____
Project Title: _____
Reviewer: _____
Date of Review _____

Content Assessment

1.0 Applicant Information – Form A is complete (3 points)

Includes ***all*** of the following elements

____ Title of Project
____ Federal I.D. #
____ Medicaid Provider #
____ FY 2007 CSHCS contract amount
____ Funds requested, matching funds contributed FY 2008 & FY 2009
____ Complete sponsoring agency data
____ Project Director signature
____ Authorized legal signature
____ County Health Officer signature
____ Secretary of State registration

NOTE: Primary and Secondary Reviewers do not need to evaluate section 1.0. Business Management staff will evaluate this section.

1.0 Score:_____
(3 points maximum)

2.0 Table of Contents

Table indicates the pages where each Section begins including appendices. □ Yes □ No

NOTE: Primary and Secondary Reviewers do not need to evaluate section 2.0. Business Management staff will evaluate this section.

***This document is an adaptation of an instrument by Dr. Wendell F. McBurney, Dean, Research and Sponsored Programs, Indiana University-Purdue University at Indianapolis. Doctor McBurney has granted permission of use of this adaptation.**

3.0 CSHCS Proposal Narrative (15 points)

3.1 Project Summary includes ***all*** of the following elements (3.1 = 10 points max.)

____ Relates to CSHCS services only
____ Identifies problem(s) to be addressed
____ Objectives are stated
____ Overview of solutions (methods) is provided

3.2 Form B **(5 points)** (3.2 = 5 points maximum)

- CSHCS Project Description (B-1)

____ Brief history is included
____ Problems to be addressed are identified
____ Objectives and workplan are summarized

- Clinic Site information (B-2)

____ Project locations are identified
____ Target population and numbers to be served by site are identified
____ CSHCS and Non- CSHCS Budget information per site is included

Comments:

3.0 Score:_____
(15 points maximum)

4.0 Applicant Agency Description

Flows from general to specific and includes ***all*** of the following elements:

4.1 Description of sponsoring agency

____ Mission statement
____ Brief history
____ Description of administrative structure (organization chart is included)
____ Project locations

4.2 Discussion of proposer's role in community and local collaboration (MOU's and MOA's attached if not previously submitted)

Comments:

4.0 Score:_____
(5 points maximum)

5.0 Statement of Need

Must address MCSHC priorities for which applicant agency is requesting funding:

- ____ Clearly Relates to ISDH MCSHC Priorities
- ____ At least one problem statement addresses either MCSHC Priority #1 or Priority #2
- ____ Specifically address one or more of MCSHC priority needs #3 - #10
- ____ Relates to purpose of applicant agency
- ____ Problem(s)/need(s) identified are ones that applicant can impact
- ____ Client/consumer focused
- ____ Supported by statistical data, available on ISDH website and local sources. Data indicates the problem(s) or need(s) exist in the community
- ____ Target populations/catchment areas are identified
- ____ Describes systems of care
- ____ Barriers to care are described
- ____ Disparities are addressed if county has significant numbers of minority population(s)

Comments:

5.0 Score:_____
(18 points maximum)

5.1 Statement of Need – Clinic or Service Provision Locations

- ____ Services located in a focus county (See Attachment E)
- ____ Services located in a HPSA (See Attachment F)
- ____ Services located in a MUA (See Attachment G)
- ____ Services located in an at-risk lead concentration area (See Attachment H)
- ____ Child health clinic(s) located in a county with inadequate child health providers as identified by OMPP (See Attachment D)
- ____ Services located in a former focus county and is a previously funded clinic location or in-home services project

NOTE: Primary and Secondary Reviewers do not need to evaluate section 5.1.
ISDH GIS/ERC staff will evaluate this section.

5.0 Score:_____
(7 points maximum)

6.0 Tables

____ CSHCS service forms and tables are completed for one or more of the proposed services.
- ____ Pregnant women
- ____ Child health
- ____ Family planning
- ____ School-based adolescent health
- ____ Family care coordination
- ____ Women's health

____ Performance objectives are included

____ Appropriate activities are included

____ Appropriate measures, documentation, and staff responsible for measuring activities are included

____ Project identifies how ISDH priority health initiatives will be incorporated into service delivery (activities on PM tables)

NOTE: Projects do not need to apply for every service (or even more than one) to receive full points for this section. Evaluators should verify that the application contains all required Performance Measure Tables for each service proposed and evaluate the quality of those tables.

Comments:

6.0 Score:_____
(15 points maximum)

7.0 Evaluation Plan Narrative

____ Project-specific objectives are measurable and related to improving health outcomes

____ Plan explains how evaluation methods reflected on the Performance Measures tables will be incorporated into the project evaluation

____ Staff responsible for the evaluation is identified

____ What data will be collected and how it will be collected are identified

____ How and to whom data will be reported are identified

____ Appropriate methods are used to determine whether measurable activities and objectives are on target for being met

____ If activities and objectives are identified as not on target during an intermediate or year end evaluation and improvement is necessary to meet goals, who is responsible for revisiting activities to make changes which may lead to improved outcomes

____ Methods used to evaluate quality assurance (e.g. chart audits, client surveys, presentation evaluations, observation); and

____ Methods used to address identified quality assurance problems.

Comments:

7.0 Score:_____
(10 points maximum)

8.0 Staff

____ Staff is qualified to operate proposed program
____ Staffing is adequate
____ Job description and curriculum vitae of key staff are included as an appendix

Comments:

8.0 Score:_____
(4 points maximum)

9.0 Facilities

____ Facilities are adequate to house the proposed program
____ Facilities are accessible for individuals with disabilities
____ Facilities will be smoke-free at all times
____ Hours of operation are posted and visible from outside the facility

Comments:

9.0 Score:_____
(4 points maximum)

10.0 Budget and Budget Narrative

____ Relationship between budget and project objectives is clear
____ All expenses are directly related to project
____ Time commitment to project is identified for major staff categories and is adequate to accomplish project objectives

Comments:

10.0 Score:_____
(8 points maximum)

10.1 Budget and Budget Narrative Forms

____ Budget pages 1, 2, and 3 are complete for each year
____ Budget narratives include justification for each line item and are completed for each year
____ Budget correlates with project duration
____ Funding received from ISDH (Form C) is complete
____ Information on each budget form is consistent with information on all other budget forms

NOTE: Primary and Secondary Reviewers do not need to evaluate section 10.1. Business Management staff will evaluate this section.

10.1 Score:_____
(4 points maximum)

11.0 Minority Participation

____ Statement regarding minority participation in program design and evaluation

Comments:

11.0 Score:_____
(2 points maximum)

12.0 Endorsements

____ Endorsements are from organizations able to effectively coordinate programs and services with applicant agency
____ Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care
____ Endorsements and/or MOU's are current
____ Endorsement or MOU with Local Public Health Coordinator
____ Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has signed Form A)

Comments:

11.0 Score:_____
(5 points maximum)

TOTAL SCORE (To be calculated by Business Management staff):_____
(100 points maximum)

CHECKLIST **To be completed by Business Management Staff**

The following forms are completed:

Application Information – **Form A**	□ Yes	□ No
CSHCS Project Description – **Form B,** (B1, B2)	□ Yes	□ No
Funding Received thru ISDH – **Form C**	□ Yes	□ No

Informing Local Health Officers of Proposed Submission

- Includes letters to all health officers in jurisdictions included in proposed service area(s) or signature(s) of health officer(s) on Form A	□ Yes	□ No

Project Performance During FY 2006

The Regional Health Systems Development Consultant (primary reviewer) should describe below performance achievements and/or problems/concerns identified in review of the FY 2006 Annual Performance Report that are relevant to this proposal.

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